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The contribution of human resources development, including in the areas of health and education, to the process of development

Extract from the report of the Committee for Development Policy on its fourth session**+

Human and social capabilities for development in a knowledge-based global society

A. Least developed countries: a widening deficit in human and social capabilities

1. Over the past 50 years, education and health systems have expanded rapidly. Schools and universities have proliferated in most countries, while provision of health services has become a multi-billion dollar global industry. Education and health indicators for both developed and developing countries have improved as investment in education and health has increased. Public expenditure on education in developing countries increased from about US$ 148 per pupil in 1990 to US$ 194 in 1997,[1] while public spending on health reached around US$ 200 per capita in 1997.[2]

2. However, there are still regions in the world that are persistently falling behind. Disparities across and within countries continue to exist. Between 1990 and 1997, overall public expenditure on education in the least developed countries remained stagnant at $39 per pupil per year while, in health, Governments of these countries spent only $6 per capita, below the minimum threshold established by the World Health Organization (WHO) of $36 per person per year for these countries. Whereas literacy rates in developing countries improved between 1990 and 1997, rising from 67 to 72 per cent, only a little over half (53 per cent) of the population of South Asia is literate. Sub-Saharan Africa and the Arab States are only slightly ahead, with 58 per cent literacy rates. Within these regions, less than half of the population of the least developed countries (48 per cent) is literate. At the primary level, sub-Saharan and Arab States have enrolment ratios of 77 per cent and 85 per cent, respectively. At the basic level of education, the gender gap is persistent throughout, especially in the least developed countries, where only 62 per cent of girls are enrolled in primary schools and only 38 per cent of women are literate.

3. At secondary and tertiary levels of education, the gaps within developing regions and between developing

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+ The document was submitted late to the conference services owing to the logistic difficulties encountered by the members of the Committee in reaching agreement on the report.

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and developed regions are even greater. While the gross enrolment ratio in secondary schools in the developed countries is measured at over 100 per cent, it is only 52 per cent in the developing countries, and only 19 per cent in the subgroup of least developed countries. Sub-Saharan Africa lags behind all developing regions with a ratio of 26 per cent. The gap is more dramatic at the tertiary level, where only 1 in 10 students in many developing countries continues on to tertiary institutions. Sub-Saharan Africa again ranks last with only 4 per cent enrolment in universities.

4. In terms of health improvement, the developing world, and African countries in particular, is lagging dramatically behind. Life expectancy has remained relatively constant during the 1990s, especially in sub-Saharan Africa, at 50 years, way behind the world average of 67 years. Similarly, this region reduced its under-five mortality only by 4 children per 1,000 live births between 1990 and 1998, while the least developed countries as a whole reduced under-five mortality by 20 children per 1,000 live births (from 171 in 1990 to 151 in 1998). A third of the sub-Saharan population remains undernourished. A quarter of South Asia remains in a similar condition. Consequently, the great majority of the countries with low levels of human capital are from sub-Saharan Africa, followed by South Asia.

B. New challenges and threats

5. Apart from lagging behind in literacy, educational attainment and health indicators, least developed and African countries in particular are today facing new challenges and threats. These arise as a consequence of globalization and the informational and technological revolution of the 1980s and 1990s. In the new knowledge-based global society, lagging human and social capabilities and a widening digital divide could exacerbate poverty and inequality, especially in Africa and the least developed countries.

6. These new exigencies emanate, to a large extent, from a required redefinition of policy goals. Globally, education systems are being redesigned: from systems that cater to the acquisition of skills and "passive knowledge", they are being transformed into systems promoting individual and collective capacity development. Similarly, in the health area, there is a move from curative to preventive services and approaches. In this process, special attention is being given to the synergies between health and education, as well as to integrated policies for capacity-building.

7. The structure and content of educational services are changing rapidly. In the past, primary-level and technical education was designed with a view towards ensuring literacy and the acquisition of basic skills so that workers, either in large factories or in rural areas, could read and follow printed instructions and blueprints. Secondary and especially tertiary education, on the other hand, was designed to prepare the technological, scientific and managerial elites entrusted with the smooth running of productive units, the promotion of innovations and the strengthening of stable governance. It is for these reasons that priority was given to universal primary education in contrast to selective enrolment in higher education. Education thus became highly hierarchical and rigid, catering exclusively to young age cohorts.

8. Today, basic literacy is viewed as a necessary but not sufficient condition for development. Individuals have to build their capacity to have access to the plethora of information that is currently available, to use it effectively in relation to their own needs and to develop analytical, synthetic and communicational skills and, more importantly, to build learning capacities throughout their lifetime. Furthermore, individuals need to build flexible skills that would allow them to adapt smoothly to changing labour markets. Finally, they need to have access to training and retraining services so that they can move freely between jobs and locations.

9. Today, in a world characterized by increased uncertainty, health for all means not only universal access to basic public-health services, improved environment and sufficient nutrition, but also the building of individual capacities to evaluate and cope with old and new health risks. Health education is rapidly becoming an important component of basic education.

10. Human resource development has thus evolved into a much broader concept concerned with the development of relevant and sustainable human and social capabilities. Development of human and social capabilities refers to the sustainable expansion of the ability of individuals, groups and institutions in a society to identify, manage and resolve existing economic and social problems, as well as to innovate

individually and collectively with a view towards improving their life prospects.

11. Today, there are pressing needs to build networks and to learn to live together in harmony with respect for and appreciation of our human diversity. Thus, the development of collective capabilities has become an integral part of, and a major priority for, human capital formation. Global environmental risks and the spread of communicable diseases require that the concept of health and education as vehicles for social development be revisited. It is necessary to look at old problems with new lenses and to use these new lenses to address the new challenges.

12. Differences between the old and new exigencies in the current global context require a shift in paradigm and new approaches to promoting social and economic development. New, innovative and holistic approaches are needed to pre-empt and deal with these challenges. The above exigencies require us to look at education and health as flexible integrated systems that should underpin lifelong capacity-building efforts.

13. Developing countries need to address these new challenges and at the same time cope with traditional problems. Many of the services provided in these countries now seem to be inadequate and/or inappropriate for development goals. This has come about for three interdependent reasons:

(a) Not only is the investment made, often with external financing, limited but it is becoming obsolete, as knowledge-based societies are redesigning their education and health systems and strategies;

(b) The lack of an integrated approach to the provision of education and health services has intensified the vicious circle, whereby inadequate education leads to poor health and poverty which in turn limit educational capacity;

(c) The fact that the systems in place have not always catered to local economic and social needs has resulted in mismatches and inefficiencies in the labour market.

14. Following in the footsteps of education and health systems of industrialized countries, education and health systems in most developing countries have grown independently of one another, providing differentiated services that are being managed by separate ministries that follow uncoordinated policy agendas. Human resource development is still identified with the training of national personnel to be undertaken almost exclusively by Governments, often with the help of foreign technical assistance and financed by official development assistance (ODA). Over the years, the limitations of such an approach have become apparent.

15. In most developing countries, health issues reflect marked social divisions. The growing gap between the well educated, the well off and the poor includes also growing disparities in health problems. Negative synergies of poverty, obsolete education and increasing health risks (including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis) lead to marginalization of the poor and create social barriers to the implementation of universal health care.

16. Developing countries therefore have to resolve a basic contradiction: while advanced technologies and globalization have resulted in rising expectations and an expanded set of needs and new opportunities, at the same time they have given rise to new challenges. It is only through the development of human and social capabilities that inequality and increased marginalization can be prevented. This requires a major overhaul of health and education systems in developing countries through the adoption of new approaches and innovative actions.

C. Approaches and innovative actions

17. Implementation of the new paradigm implies, inter alia: (a) developing and capitalizing on synergies between education and health; (b) securing universal access to integrated services; (c) securing high quality and flexibility in educational and health systems; (d) building innovative institutional frameworks; (e) reinforcing social capabilities; (f) harnessing opportunities brought by new tools, such as information and communication technologies (ICT); (g) designing innovative financing schemes; and, most importantly (h) forming local and global partnerships to face these new challenges.

1. Synergies between education and health

18. A new understanding of the meaning of health includes not only the fight against diseases but also the creation of the conditions needed for an active life. This cannot be achieved without building stronger

synergies between health and education. Synergies have two-way effects: more learning means more capacity for self-regulation and responsible behaviour, helping to preserve good health and avoid health risks. Better health and fitness mean more opportunities for lifelong learning and more capacity for intensive use of information. Moreover, human resource development is a prerequisite of coping with damaged health and disabilities after crises, wars and natural disasters.

19. Health and education have synergy effects on other development objectives — individual and collective empowerment, protection of the environment and good governance. Educating people for development should therefore promote a balance among economic goals, social needs and ecological responsibilities and provide people with the skills, perspectives, values and knowledge to live in sustainable communities. Moreover, social capacity-building should foster attitudinal changes and new ways of thinking about sustainable development.

20. It is increasingly recognized that incorporating gender perspectives in different areas of development ensures a more effective achievement of economic and social goals, as reflected in the United Nations Millennium Declaration.[3] In health and education, targeted interventions should address women's needs and gender equality, as women represent a linchpin of the relation between health and education, and their contribution is essential for attaining social goals.

21. In this light, women's literacy is an important key to improving health, nutrition and education in the family and to empowering women to participate more in decision-making in society. Investing in formal and informal education and training for girls and women, with its high social and economic return, has proved to be one of the best means of achieving economic growth that is both sustained and sustainable. Governments, the private sector and civil society should ensure that schools and informal systems of education play a stronger role in preventing infection from communicable diseases, especially HIV infection. Education should also play a role in eliminating discrimination against women through the inclusion of gender-sensitive education about safer sex and responsible behaviour.

2. Securing access

22. Currently, the relationship between the community and school is often one of alienation, especially in the case of households that have low literacy rates. Recent development of community schools with greater involvement of families constitutes a major breakthrough, creating strong incentives towards increased enrolment and retention at the basic level. The creation of vocational and technical community-based schools distributed throughout a country is also likely to increase accessibility and relevance of education.

23. Enhancing participation also implies the elimination of regional or cultural impediments to the access to health and education. Peer group pressure, community and non-governmental organization involvement could and should play an active role in securing access.

24. Recent economic crises and the subsequent stagnation and decline in economic growth in many developing countries have produced declining enrolments in schools and a deterioration of health, especially among young people from the rural communities, girls and the economically disadvantaged groups in society. AIDS orphans, in particular, constitute a growing proportion of early school-leavers. To ensure universal access to basic health and education services, the following actions are necessary:

(a) Policies should be geared to mobilize the family and enlist community support and financial assistance. The expansion of pre-school education, the training of parents and the development of networks between full-day preparatory and primary schools that would provide boarding and care for children from socially disadvantaged families are important steps in safeguarding community acceptance and participation. The provision of school lunches with minimal family/community contribution is a powerful incentive for enlisting community support and participation;

(b) Setting minimum standards for public expenditures in education and health. All children should receive basic education of good quality through the public provision of primary education, especially in the least developed countries. Information and communication technologies can be used to promote teacher training and to reach larger numbers of children. Retired teachers could be rehired to meet the existing shortages of teachers, while new ones are being trained;

(c) Integrating basic education with basic training, including the provision of traditional skills,

basic health training and computer literacy. Also, it is important to stimulate, in the process, environmental awareness and to develop teamworking skills.

25. Securing access also implies investing in secondary and tertiary education, inter alia, in poor countries, so as to enhance the available stock of skilled personnel and to meet the rising shortages of teachers and doctors. Investment in tertiary education, which can be pursued more effectively in a regional context, especially among poor countries, is important for improving governance, as well as regional and national capacity-building.

3. Securing quality and flexibility

26. Emphasis on achieving high educational and health standards based on numerical indicators often misses the more subtle dimensions of quality. In the area of education, two important aspects of quality need to be differentiated: first, the extent to which education contributes to building human and social capabilities and the fulfilment of human potential; second, the extent to which the educational process succeeds in advancing the acquisition of skills necessary for employment.

27. The above differentiation implies that a country could build its human capital while missing some of these quality aspects. As this has been observed in many high-income countries, the problem is not unique to the developing world. Ensuring quality is tied to having quality standards for evaluating the development of human and social capabilities.

28. While recognizing that the establishment of new standards is almost always resisted by entrenched interests, the Committee stresses that, without uniform standards for evaluating progress, there are no means of determining the effectiveness of investment in education. For example, standards for the quality of teachers should be developed, periodic checks at the local and national levels should be executed, and incentives should be created to attract the most qualified to the teaching profession.

29. Standard measures of education achievement in terms of enrolment ratios and number of students finishing primary education are imperfect measures of quality. Hence, there is a need to establish tests and other procedures that can capture "functional illiteracy", even in cases of high enrolment ratios.

30. Standard measures focus on formal education, yet informal educational processes — such as those taking place in households and communities — also contribute to the acquisition of knowledge. However, there are no means to evaluate and measure these contributions. The acquisition of skills through informal processes affect women in particular since many women only acquire informally the skills they use for survival and support of family — whether in unpaid household production or in informal paid production (such as crafts, house-based work etc.).

31. If school curricula are not relevant to the development realities of the country, societies are not able to achieve the optimum return on their investment. Despite decades of independence, the content of the education curriculum in many African countries has not changed significantly from the content that was in place during the colonial periods. Economic globalization, health threats like HIV/AIDS, environmental degradation, and ICT demand that education curricula be modified to generate the social capital required and to address these and other challenges that now confront developing countries. Failure to do so would further contribute to their marginalization in the global society and make poverty a fact of life for future generations.

32. Quality is also linked to the level of expenditures on education and health. High expenditures result in high education and health quality, as long as they are adequately designed. There is therefore an urgent need to increase expenditures in areas where these are low.

33. The capacity to adjust and resilience in the face of rapid change and shocks reside to a great extent in the ability of a society to adapt quickly and efficiently to these changes. A country's adaptive capacity for the future is determined, among other things, by programmes in education and health, which secure flexibility in terms of adapting and reshaping themselves. The Asian financial crisis and the experience of many countries that implemented structural adjustment programmes during the past two decades have shown the need for flexibility in the design and implementation of health and education programmes aimed at the social groups most adversely affected by such experiences. However, most countries have been unprepared for this task. Therefore, the Committee urges that an effort be made to increase flexibility and allocate resources to this end.

34. Flexibility can also be viewed as a part of the social protection programmes dealing with the negative effects of globalization, particularly unemployment and loss of access to health insurance affecting the most vulnerable sectors of the population. Empirical evidence suggests that there is a positive correlation between a country's openness and its provision of social protection.[4] This protection allows smooth transitions to new employment with the help of different programmes — ranging from unemployment funds and short-term training and retraining programmes to the provision of funds for longer-term access to formal education.

35. In African countries, in part because of the large proportion of school-age population and the rigid framework of the existing educational system, school-leavers seldom have the opportunity to return to school. Because of certain social constraints, including motherhood and household chores, women have even fewer opportunities. Rethinking the school calendar in accordance with seasonal job requirements, instituting evening classes and opening schools during holidays can provide more flexibility so that the entire population can be included. Lifelong learning, with greater emphasis on flexible entry points, will encourage, among other things, the bridging of the current gender gap at all levels of education.

4. Building innovative institutional frameworks: a new role for government

36. In the past, Governments of developing countries were seen as the main driving forces of change, since markets and civic organizations were not well developed. The provision of educational and health services was viewed as coming under an exclusive government responsibility to secure basic human rights and the supply of certain public goods. As a result, the overpresence of Governments has often caused problems: overregulation, rigidity, corruption, inefficiency, and suppression of initiatives and dynamism from the private sector and civil organizations.

37. In the new paradigm, the provision of education and health services is viewed as a shared responsibility among Governments, individuals, the private sector and civil organizations to create an environment that would secure the full development of human capabilities and a supply of both private and public goods. Governments will still play a leading, albeit modified role, not only continuing to provide these services but also increasing oversight and regulating private sector activities where necessary, in order to assure healthy competition in the provision of services. Private sector participation in educational and health service provisions may bring new standards to an area previously dominated by public administration. Civil organizations and grass-roots movements could also play an increasing role in the future, since they are much closer to the final recipients of educational and health services.

38. To apply this shift in the development paradigm, particularly in sub-Saharan Africa, innovative institutional frameworks are needed. These should be multisectoral in focus and should facilitate mainstreaming of health and education matters into the overall development process of the nation. Innovative institutional frameworks must address those cross-cutting issues that lie at the nexus of education and health and whose existence are indicative of bottlenecks or failures in the system, such as brain drain, gender inequality, and child labour.

39. Innovative institutional arrangements for delivering health and education services must encourage (and not frustrate) the participation of all strategic stakeholders — government, the private sector, non-governmental organizations, workers and employers' organizations etc. They must be open to allow each partner to work in areas and on issues in respect of which it has demonstrated a comparative advantage. Since this is a fast-moving world, such institutional arrangements must contain mechanisms for monitoring trends and the impact of interventions on social groups, in particular the more vulnerable groups. It should also have mechanisms for self-correction, self-adjustment or self-abnegation, if necessary.

40. In the present era, markets are relatively better developed, so that Governments need to focus on making all components of the education and health system work more effectively and efficiently — the private sector, government and civil society. The more developed the market is, the more participatory the system could and should be. In such an environment, Governments should:

(a) Set priorities and national agendas;

(b) Provide information and promote monitoring;

(c) Set standards for measuring access quality, flexibility and effectiveness;

(d) Ensure access to those who are currently unable to participate.

41. Given the vast scale of human resource needs in the health and education sectors, it is unreasonable to expect Governments to face these challenges alone. One of the critical priorities for government action should be the facilitation and nurturing of broad-based alliances and partnerships locally, nationally and globally to jointly address the deficit in human resource capabilities. For such partnerships to be effective, it is necessary for Governments to create appropriate legislative and institutional arrangements and to develop coordination mechanisms that ensure synergy and accountability across the activities of the various partners.

5. Reinforcing social capabilities

42. Social capabilities refer to the capabilities of a society to organize itself for development. Social capability is a multifaceted attribute: it includes capabilities related to education and health, as well as to legal and financial systems. It also includes collective attributes that make the economy and society more effective and efficient.

43. Capacity-building must take place at all levels of society — national, provincial and local. It is only when a local community acquires the capacity to design and create its own future that genuine development can take place, enabling it to choose among different technological and social options and adopt those that are most appropriate. In time, capacity grows with the reinforcing of institutions and infrastructure of all types — social, physical and financial. In this endeavour, it is important to understand the interrelationships among economic, health and education issues, especially the connections among poverty, gender inequality and HIV/AIDS.

44. In the era of globalization, knowledge is a strategic factor in competitiveness. Therefore, investments in social capabilities have high returns with regard to economic growth and technological change. In recent years, there has been a gradual realization of the need for investing in social capital. There appears to be increasing interest in strengthening local economies through the creation of closer-knit supportive communities and the provision of microcredit.

45. High social capabilities ensure that human potential can be developed and utilized fully. To build such social capabilities, it is important to:

(a) Provide access to health and education to all strata of the population;

(b) Promote value systems in which honesty, fairness, transparency, human rights, freedom, and a guaranteed democratic decision-making system are nurtured;

(c) Strengthen key systemic capabilities, including legal, educational and financial systems based on the foundations of the value system noted above;

(d) Promote discipline with a law-based governance structure and a fair market system.

46. Many societies in the developing world have social problems that inhibit and even destroy human capabilities. Among the most debilitating problems are corruption which often permeates the entire society, and drug abuse. Unless corruption and drug abuse are directly confronted and dealt with, efforts expended on building social capabilities and innovative institutional frameworks may end up as an exercise in futility.

6. Information and communication technologies (ICT)

47. The decade of the 1990s saw the maturation and wide-scale deployment of ICT across the developed countries. The diffusion was possible through the use of computers and communication that ushered in the Internet. While the use of ICT is regarded as standard operating procedure for business, government and civil society in the developed countries, this is not yet the norm in the majority of the developing countries, particularly the least developed countries.

48. Based on the lessons learned, ICT has great potential to transform the way developing-country societies conduct business and help to address the persistent social problems of education and health services. However, in the vast majority of cases, ICT is yet to be utilized for such purposes. The delays in exploiting the opportunities offered by ICT may further increase the already wide gaps in the quality of life of citizens living in developing countries, particularly those in the rural areas. ICT, effectively utilized, will make major contributions to education and health in the developing countries through:

(a) Expanding coverage of education and health delivery services;

(b) Improving the quality of education and health delivery services;

(c) Reducing the cost of education and health provision.

49. A new ICT-based curriculum for health and teacher training should be developed with a focus on social capacity-building, including basic knowledge and skills in community work, social networking, social rehabilitation, methods of teamwork, health risks prevention and intercultural communication. ICT-based programmes should be created for incorporating knowledge, traditions and skills of indigenous cultures into contemporary knowledge-management systems for use in education and health management. Well-designed ICT services, including e-learning at the tertiary level, can be adjusted to community needs and facilitate lifelong learning.

50. To expand the pool of knowledge available for addressing the new challenges in health, particularly the shortage in the number of trained medical personnel, Governments should not only utilize the newer forms of knowledge (ICT) but also, as a matter of policy, provide appropriate support to indigenous systems of preventive and creative medicine that still cater to the needs of a substantial proportion of the population.

51. ICT can also help to improve women's health by generating knowledge, information and policy advice that could be applied to making the health system more responsive to women's needs. Health conditions could also be improved through spreading of information via ICT about health horms, availability and quality of resources and their pricing. In parallel, the decentralization of management will help to bring health services nearer to communities and to strengthen their accountability with respect to resources.

7. Innovative financing

52. Given the growing need for additional investments in health and education to address factors such as globalization and HIV/AIDS, Governments will need to pursue innovative approaches to mobilizing resources. Potential areas suggested for resource mobilization include:

(a) *Household contributions.* The primary responsibility for health and basic education lies within the household. While economically stressed households have limited resources, a large number of small contributions can amount to substantial resources. Inducing households to respond in such a manner will require full partnership. This implies their participation in processes like policy formulation, and choosing teachers, doctors, and curriculum content etc. from which they might have been previously excluded;

(b) *Community contributions.* While most poor communities look to government for education and health services, there is growing evidence that communities can be mobilized to make significant contributions to basic education and health. Communities could undertake special events and make in-kind contributions that eliminate the need for the provision of some resources. For example, communities can contribute to the maintenance of health and education infrastructure which can then be used to serve wider community needs. As with households, this would create a different relationship between local government and the communities — a relationship in which communities are full partners with government and use their resources to supplement those of the government in the implementation of a common agenda;

(c) *Private sector contributions.* The success of the private sector to a large extent depends on the capacity and health of its employees. Therefore, it has vested interests in supporting quality education and health services. The Government's relationship with the private sector, in the majority of developing countries, is limited to revenue collection in the form of taxes and duties. As with communities, getting the private sector involved in education and health will require a redefinition of this relationship. Towards this end, Governments can provide a friendly environment in which the private sector is a contributing partner. Greater efficiency in the provision of health and education services would eventually benefit all sectors;

(d) *Local government.* Traditionally, local governments have operated based on policy and directives established by the central government with rather limited inputs from the communities that they serve. The process of decentralization that is now being implemented by most developing countries is intended to ensure greater participation of communities in planning and decision-making. Local government in

partnership with communities and the private sector represents a new mechanism with significant potential to improve the effectiveness of education and health services. This would also require the allocation of resources to the local level, either through transfers or through local revenue requirements;

(e) *National government.* The responsibility for the overall allocation of resources is the responsibility of national government. Recognizing the strong synergy between education and health, Governments could consider integration between these two separate portfolios, in order to realize synergies that would eventually increase these allocations. Better education has been shown to significantly improve health status;

(f) *Increasing 20/20.* According to the consensus on the so-called 20/20 formula reached at the World Summit for Social Development in 1995, developed and developing countries are committed to providing respectively 20 per cent of their ODA and 20 per cent of their budget to the social sectors.[5] However, overall levels of public social spending have been declining in most parts of the developing world.[6] Fulfilling this pledge would increase significantly the resources available for investing in health services and education;

(g) *Increasing ODA.* Since the late 1960s, donors have committed themselves to providing 0.7 per cent of gross domestic product to ODA. This commitment was reaffirmed at the World Summit for Social Development held in Denmark in 1995. However, the trend of decline in donor contribution to ODA is continuing. This has adversely affected flows to the least developed countries and has aggravated resource constraints, especially in the areas of health and education. Donor countries once again recognized, at the International Conference on Financing for Development, held in Monterrey, Mexico, in March 2002, that a substantial increase in ODA is required in order to achieve the development goals and objectives set in the United Nations Millennium Declaration.[7] In that light, concrete steps should be taken so that the pledges made in Monterrey are fulfilled;

(h) *International Global AIDS and Health Fund.* The Committee welcomes the initiative of the G-8 countries to provide for a special fund to fight the spread of HIV/AIDS, particularly in Africa, and encourages further commitments from the industrialized countries.

(i) *Innovative financial sources.* Even with successful implementation of the above measures, developing countries will face resource constraints in respect of financing education and health which are increasingly becoming global public goods. The Committee therefore suggests that new avenues for resource mobilization (for example, a carbon tax, levies on financial transfers and rent for the use of airspace and territorial waters etc.) be explored to finance the development of human resource capabilities in developing countries, most notably in Africa.

8. Forging partnerships

53. Greater reliance on local initiatives involving people-to-people interaction and the value of alliances and partnerships among Government, civil society and the private sector should be encouraged. In that light, partnerships should be encouraged within local communities among employers, organizations, trade unions, education authorities, training providers etc. in order to ensure the quality of public and private sector training and education. Youth organizations should be encouraged to take initiatives and actions at community and national levels.

54. Besides partnerships at the local and national level, partnerships for development at the regional and/or global level can be important institutional mechanisms and vehicles for capacity-building in developing countries based on the growing recognition of regional and global interdependence. Partnerships for capacity-building and human resource development can increase both the quantum of available resources for education and health, and the effectiveness of policies of developing countries. In this connection, the Committee welcomes the fact that the revised paper of the Chairman of the Commission on Sustainable Development acting as the preparatory committee for the World Summit on Sustainable Development (A/CONF.199/PC/L.1/Rev.1) recommended the promotion of partnerships in science and education as well as health issues related to sustainable development in preparation for the Summit, to be held in Johannesburg, South Africa, from 26 August to 4 September 2002.

Notes

[1] All data on education are taken from the *World Education Report 2000* (Paris, UNESCO, 2000).

[2] *Macroeconomics and Health: Investing in Health for*

Economic Development, report of the Commission on Macroeconomics and Health (Geneva, WHO, 20 December 2001).

[3] See General Assembly resolution 55/2 of 8 September 2000.

[4] Dani Rodrik, *Has Globalization Gone Too Far?* (Washington, D.C., Institute for International Economics, 1997).

[5] See Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development (*Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995*) (United Nations publication, Sales No. E.96.IV.8), chap. I, resolution 1, annexes I and II, especially annex II, para. 88 (c).

[6] See para. 35 of the report of the Secretary-General (E/CN.5/2002/3) entitled "Integration of social and economic policy", submitted to the Commission for Social Development at its fortieth session (11-21 February 2002).

[7] See para. 41 of the Monterrey Consensus (A/CONF.198/11, chap. I, resolution 1, annex), outcome document of the International Conference on Financing for Development.